Division of Health Care Facilities

TN1916 STREET ADDRESS, CITY, STATE, ZIP CODE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ASHVILLE, TN 37215 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (B. WING					A. BOILDING			<u>.</u>	
GREENHILLS HEALTH AND REHABILITATION CENTE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE			TN1916		B. WING				
CALCAPTECE CALCAPTE CALCAPT	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
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	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	I CORRECTIVE ACTION SHOULD BE COMPLETE REFERENCED TO THE APPROPRIATE DATE		
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Complaint investigation # 35340 was completed at Green Hills Health and Rehabilitation Center on January 13, 2015. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes	IN OOC	Complaint investigati at Green Hills Health on January 13, 2015. under Chapter 1200-	and Rehabilitation Cer . No deficiencies were	nter cited	N UUU				

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE